TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Fort Worth

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-17-2925-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note per the NCCI edits this line is not bundled and we show should have processed for payment."

Amount in Dispute: $59.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One of the codes billed, 96361, Texas Mutual denied because the payment is entailed by comprehensive code 99285. The NCCI Edits do indicate payment could have been made for code 96361 by the use of an appropriate modifier. Review of the bill shows no modifier used by the requestor on that code. By offering no explanation the requestor failed to address this issue. No payment is due."

Response Submitted By: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2016	96361	$59.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers compensation state regulations/fee schedule requirements
    - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
    - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
    - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
    - 724 – No additional payment after a reconsideration or services

Issues

1. What is the applicable rule that pertains to reimbursement?

Findings

1. The requestor is seeking $59.93 for outpatient hospital services with date of service October 11, 2016. The carrier reduced the payment amount as 235 – "This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers compensation state regulations/fee schedule requirements."

   The service in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

   The relevant portions of 28 Texas Administrative Code 134.403 are:

   (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

   (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

Review of 2016, Chapter XI, National Correct Coding Initiative Policy Manual at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html;

15. CPT codes 96361 and 96366 are utilized to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes may be reported only if the infusion is medically reasonable and necessary for the patient's treatment or diagnosis. They should not be reported for "keep open" infusions as often occur in the emergency department or observation unit.

Therefore, the carrier's denial is supported. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.